IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7005 1160 0000 1506 9001

September 12, 2008

Monica Brutsman, Administrator
Trinity Mission Health & Rehab of Holly, LP
2105 Twelfth Avenue Road
Nampa, ID 83686

Provider #: 135094

Dear Ms. Brutsman:

On **September 2, 2008**, a Complaint Investigation survey was conducted at Trinity Mission Health & Rehab of Holly, LP by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567, listing Medicare/Medicaid deficiencies, and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567 and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 25, 2008**. Failure to submit an acceptable PoC by **September 25, 2008**, may result in the imposition of civil monetary

penalties by **October 15, 2008**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **October 7, 2008 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **October 7, 2008**. A change in the seriousness of the deficiencies on **October 7, 2008**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 7, 2008** includes the following:

Denial of payment for new admissions effective **December 2, 2008**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 2, 2009**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 2, 2008** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **September 25, 2008**. If your request for informal dispute resolution is received after **September 25, 2008**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Loretta Todd

LORETTA TODD, R.N.
Supervisor
Long Term Care

LT/dmj

Enclosures

IDAHO DEPARTMENT OF
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FAX 208-364-1888

October 14, 2008

Monica Brutsman, Administrator
Trinity Mission Health & Rehab of Holly, LP
2105 Twelfth Avenue Road
Nampa, ID 83686

Provider #: 135094

Dear Ms. Brutsman:

On **September 2, 2008**, a Complaint Investigation and State Licensure was conducted at Trinity Mission Health & Rehab of Holly, LP. Marcia Key, R.N. and Arnold Rosling, R.N., Q.M.R.P. conducted the complaint investigation. A total of 14 survey hours were required to complete the investigation.

An immediate tour of the facility was conducted to observe residents for visible bruising and for possible indications of pain.

The following documentation was reviewed:

- Incident/Accident reports and grievances from June through August 2008;
- Resident Council minutes for June and July 2008;
- Seven residents' records including the identified resident;
- The facility's policies/procedures on MD Notification, Accidents and Incidents and Rules for faxing MD.

Five residents and seven staff members were interviewed, including the administrator, Director of Nursing, wound care nurse and a physical therapist. The ombudsman and one of the complainants were interviewed by phone.

The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003703

ALLEGATION #1:

The complainant stated an identified resident sustained a fall in the facility on or around July 17, 2008, which resulted in bruising to the left side of her face, a cut over her left eye, blurred vision and left side pain.

FINDINGS:

The facility's Incident Report, dated/timed July 16, 2008, 6:25 p.m., documented the identified resident sustained a fall after attempting to ambulate in her room without the assistance of her walker or staff members. A nurse who determined the resident had full range of motion of her extremities without any guarding or grimacing during the examination immediately assessed her. The resident sustained a small cut on her left eyebrow and a small hematoma above her left eyebrow that caused discomfort when the nurse touched the area during the examination.

The Neurological Assessment form documented the licensed staff members performed neurological assessments every fifteen minutes for the first hour after the fall, hourly for the next two hours, and then every four hours through July 17, at 5:30 p.m. Her neurological status remained within her normal limits.

The Pain Management form documented the resident routinely received the pain medication, Norco, for "general and back pain" since the day of admission to the facility. After the fall, she continued to receive the scheduled medication for the "general and back pain."

There was no documented evidence the resident requested or required more frequent or more effective pain management during the reminder of her stay in the facility.

There was also no documented evidence the resident had any changes in her vision after the fall.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated that after an identified resident fell in the facility that resulted in injuries, the responsible party was not notified until the following day.

FINDINGS:

Review of the identified resident's record and Incident Report revealed that neither the treating physician nor the responsible party was immediately notified after the resident sustained a fall in the facility.

The facility sent faxed assessment findings to the office of one physician on July 16, and a second physician on July 17, 2008, however, the facility did not ensure the physicians actually received the

faxed documentation.

The facility was cited at federal regulation F157 for this deficient practice.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant stated that after an identified resident fell in the facility sustaining facial bruising, a cut over her left eye, and blurred vision, she was not immediately sent to an Emergency Room or seen by her treating physician.

FINDINGS:

Review of the identified resident's record revealed the resident did not sustain any serious injuries that required an immediate evaluation by a physician. The facility's licensed nurses closely monitored the resident.

The resident's record documented the facility was in contact with the physician regarding other medical concerns for which the resident was scheduled to be seen by the physician on August 18, 2008.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135094	A. BUILDING _____ B. WING _____	C 09/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY MISSION HEALTH & REHAB OF HOLLY	2105 12TH AVENUE ROAD NAMPA, ID 83686

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F 000	INITIAL COMMENTS The following deficiency was cited during a complaint investigation of your facility. The surveyors conducting the survey were: Marcia Key, RN, BSN, WOCN Arnold Rosling, RN, QMRP Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000		
F 157 SS=E	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident	F 157	See attached P.O.C Trinity Mission Health & Rehab. of Holly, L.P. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed. Solely because it is required by the provision of the Federal and State Law. RECEIVED SEP 23 2008 FACILITY STANDARDS	9-16-08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mona Bowman RN NHA	Administrator	9-19-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on a complaint from the general public, record review, and staff interviews, it was determined the facility did not ensure treating physicians and residents' responsible parties were immediately notified, as required, after residents were involved in incident/accident occurrences in the facility. This involved 4 of 4 sampled residents (#1, 2, 3, 4) reviewed for accidents. Findings include: 1. Resident #1 was admitted to the facility on 4/2/08 with diagnoses which included bilateral heel wounds, depressive disorder, and hypertension. An Incident Report, dated 7/16/08, documented the resident sustained a fall in her room at 6:25 pm, resulting in a hematoma to her forehead and a laceration over her left eyebrow. The hematoma and laceration were measured, however, the documentation in the report and the nurses notes was not legible to be able to determine if the injuries were measured in centimeters or millimeters. The size of the hematoma was "2 1/2	F 157		

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F 157	Continued From page 2 [not legible]" and the size of the cut was "[less than] 1/8 x 1/4 [not legible.]" The Incident Report's Notification section identified the following line entry information to be completed by the LN: Family, Relationship, Date, and Time; and Physician, Attending, On call, Date and Time. The form did not include entry information which would identify the means of contact, for example via telephone, fax, or in person. The Notification section contained documentation the resident's daughter was notified and the date/time of 7/17/08 at 10:20 am, which was 16 hours after the accident. The Notification section also identified the name of the treating physician and the date/time of 7/16/08 at 11:30 pm. The word "faxed" was handwritten on the form. Resident #1's record included a copy of the fax which contained the following sections: *ATTENTION DR. The treating physician's name was identified. *There were three boxes identified as: URGENT, Needs Response, and FYI (for your information.) The FYI box was marked with an "X" by an LN. *The Information section contained the same fall and injury documentation that was identified in the Incident Report. It was signed by an LN and dated 7/16/08. It also included, "Faxed 7-16-08 2300 [11:00 pm.]" *The Response section was left blank and there was no physician signature or date. There was no documented evidence the physician had actually received the fax.	F 157		

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F 157	Continued From page 3 A second fax was sent to a second physician on 7/17/08 at 10:30 am, and was marked as, "Needs response." The physician Response section contained only an undated physician's signature and the word "noted," which was written by an LN and dated/timed 7/21/08 at 2:15 pm, five days after the resident's fall. There was no documented evidence the physician received the fax immediately after it was sent. The nurses notes were reviewed from 7/17 through 7/21/08. The documentation did not include any statement that the fax was received by the treating physician. The DON was interviewed on 9/2/08 at 1:50 pm. The survey team asked her how the facility ensured that a fax, sent to a physician, was actually received by the physician, rather than merely being faxed to a specific location. The DON indicated that the LNs needed to be sure the fax was received at the intended location. She was asked again if merely sending a fax was considered by the facility to be actual notification by the physician. She stated, "Unless we need a response it is acceptable." She also indicated that if a fax was marked, "Needs Response," and the LNs do not receive a response to the fax, they are to call the physician. NOTE: Although Resident #1 hit her head, which resulted in a hematoma and laceration, the LN marked the fax to the treating physician as "FYI" only. The DON was asked to provide a copy of the facility's fax procedure. The DON was also asked why Resident #1's family was not immediately	F 157		

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F 157	Continued From page 4 notified after the resident fell and sustained the injuries. The DON stated, "[Resident] considered herself her own person so we would not call (family) without telling her. She was independent and wanted to direct things." The DON was again interviewed at 2:25 pm. She provided a copy of the facility's MD Notification procedure. This document did not address the fax procedure. The survey team again asked for this document. The DON again indicated that Resident #1 was her own responsible person, and that calling a family member without the resident's permission, "Would almost be like gossiping." The Administrator was interviewed on 9/2/08 at 2:35 pm. She was informed of the survey team's concern that LNs were not ensuring that physicians immediately received faxes. She stated, "If the staff don't get a response [from the fax] it's a judgment call," (whether or not to call the physician.) She also stated, "If it's not critical the staff do not need to notify the physician except with a fax." She was shown the Federal Regulation F157 regarding immediate notification to physicians and residents' responsible party. The Administrator was also shown the Informational Letter #2000-01 from the Bureau of Facility Standards (BFS,) dated March 1, 2000, addressed to: "All Idaho Nursing Facilities," SUBJECT: "Fax Notification of Physicians." The Informational Letter documented in part: "...1. Is a fax considered to meet the requirement for immediately consulting with the physician? ANSWER: Not necessarily.	F 157		

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F 157	Continued From page 5 2. Is it appropriate to assume that if the physician does not respond to the fax, the facility has met their obligation of consulting with the physician and no further action is needed? ANSWER: No. Unless the physician responds to the fax immediately, there is no way to ensure that the physician is in the office and/or that he/she received the fax. There is no assurance that the fax was received unless the office is contacted to confirm the fax was received and relayed to the physician. The Department's position (in bold) is that an unconfirmed (underlined) fax will not be considered physician notification until such time as the physician makes return contact to the facility. In other words, if the physician does not respond to the fax, the Department will not assume that the physician received the fax and choose not to answer it. Instead the Department will consider this a finding of noncompliance with F157..." The Administrator requested and received a copy of the Informational Letter. The Administrator stated she would check the 24 hour fax report form to verify the treating physician received the fax, and provide this information to the survey team. NOTE: As of 9/5/08 this documentation had not been received by the BFS. The Administrator was again interviewed on 9/2/08 at 3:10 pm. The survey team informed her that the DON indicated Resident #1 was her own decision-maker and therefore her family did not need to be notified of occurrences unless requested by the resident. The Administrator indicated the resident did make her own decisions and she would review the record for this	F 157		

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F 157	Continued From page 6 documentation. Shortly later the Administrator provided a copy of a social service note, dated 7/2/08, that pertained to the resident being notified of her Medicare benefits. The note documented in part, "..Explained to fam[ily] that pt [patient] is her own decision maker." The Administrator was asked to provide documented evidence that the resident specified she did not wish her family to be notified in the event of an accident or occurrence in the facility. As of 9/5/08 this documentation had not been received by the BFS. The DON was again interviewed on 9/2/08 at 4:50 pm. She provided the document, Rules for Faxing MD. The form was not dated. She was asked when the procedure was written and implemented. She indicated she came to the facility in September 2006 and developed the rules for faxing, "sometime shortly after that." The procedure directed in part: "...3. Report to the oncoming shift what you have faxed. 4. Document in the nurses notes WHO you fax, what time and if this was an urgent matter and you were requesting immediate attention or if you were presenting routine information. YOU MUST DOCUMENT IN THE NURSES NOTES WHEN YOU FAX A DOCTOR. 5. If what you have to say to the doctor requires an immediate response, you must call the office and verify that the fax has been received and that the MD will actually address it. Again, document when you call and to whom you speak... Fax follow-up: 1. Check for return faxes. If none, document on the fax 'Second Request' and write the date and time you are re-faxing.	F 157		

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F 157	Continued From page 7 2. Call the office and document with whom you speak when you ask for a response to the fax. 3. If you cannot get a response from an MD please notify the ADON [Assistant] or the DON so that we may help you." After the exit conference on 9/2/08 at approximately 5:30 pm, the Administrator acknowledged that part of the federal regulation (F157) requirement was not being met in the facility. She stated, "Pieces of the reg [regulation] are missing." 2. Resident #2 was admitted to the facility on 5/17/07, with diagnoses which included Diabetes mellitus, congestive heart failure, arthritis, and depression. An Incident Report, dated 6/23/08 at 10:30 am, documented that as a CNA was assisting the resident in the bathroom, the resident's knees "buckled" and she bumped her head on the wall. The nature of the injury was a "bump." The report documented a family member was notified, however, there was no date or time of the notification. The nurses note documented, "Late entry 6/24/08 0900 [9:00 am] Yesterday [around] 1030 [on] 6/23 [Resident] was attempting to stand from being toileted when knees 'buckled'...no skin break, no swelling or redness. No c/o [complaint of] pain. MD notified..." The nurses note did not document that the family member was notified. 3. Resident #3 was admitted to the facility on 10/20/06 with diagnoses which included	F 157		

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TRINITY MISSION HEALTH & REHAB OF HOLLY	2105 12TH AVENUE ROAD NAMPA, ID 83686

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F 157	Continued From page 8 Alzheimer's disease, hypertension, osteoporosis, and depression. An Incident Report, dated 7/15/08 at 3:15 pm, documented the resident was found to have a skin tear to her right forearm approximately one inch in length. The Incident Report documented the family member was not notified until the following day on 7/16/08 at 11:00 am. The report documented the treating physician was notified on 7/15/08, no time or method of notification was recorded. The fax communication form documented the physician signed the fax report on 7/22/08, and wrote, "noted." This was seven days after the incident. The Administrator was interviewed at 3:40 pm regarding the facility's practice of faxing documentation to the physician. She stated, "In the Incident Report, unless the nurse writes in the word 'faxed' to the MD, the MD is called. She was asked to provide documentation in the nurses notes that the treating physician had been called. As of 9/5/08, no further documentation had been received by the BFS. 4. Resident #4 was admitted to the facility on 6/23/08 with diagnoses which included diabetes mellitus, hypertension, arthritis, and hip fracture. An Incident Report, dated 7/16/08 "prior to lunch," documented the resident was found to have a "slight red discoloration over large area" to her right forearm. The Notification section documented the treating physician was notified on 7/17/08 at 10:00 am, no method of notification was identified. The Family section contained the	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135094	A. BUILDING _____ B. WING _____	C 09/02/2008

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F 157	Continued From page 9 word "self." On 9/2/08 at approximately 5:00 pm, the Administrator was asked to provide documentation that the resident requested family/responsible party not be notified in the event of an incident/accident. As of 9/5/08, no documentation had been received by the BFS. The resident's record contained a fax communication form, signed/dated by an LN on 7/17/08, no time recorded, which documented the resident had a "reddish/purplish bruise on R[ight] forearm - 3 1/2" x 2" - skin intact..." The form included a physician signature, however, this was dated 7/1/08 (date prior to the incident,) and the entry, "OK." The form also contained a handwritten entry, "Noted 7/18/08 [LN initials.]" The nurses notes, dated 7/17/08 at 10 am, documented, "[Treating physician] notified of the bruise..." The method of notification was not identified. The facility failed to have a system in place to ensure the treating physicians and residents' families/responsible parties were immediately notified after accidents involving residents in the facility.	F 157		

Ftag 157 E Notification of changes

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident with injury, significant change, a need to alter treatment significantly, and transfer or discharge from the facility.

Corrective action for those residents effected.

- Resident # 1 has discharged from the facility.
- Resident # 2 residents family was re notified of incident on 9-16-08
- Resident #3 resident's family was notified on 7-16-08
- Resident #4 resident's record was updated to accurately reflect notification of physician and family.

Plan to identify other residents that have the potential to be effected.

- Residents that reside in the facility and experience a significant change of condition, accident with injury, or discharge from the facility have the potential to be effected.

Systemic changes and monitoring to ensure continued compliance

- On 9-11-08 Licensed staff were re-inserviced on regulation F157.
- Licensed staff re-inserviced 9-11-08 on Informational Letter #2000-01 regarding fax notification of Physicians.
- Unit Managers and DNS will audit Incident/Accident reports after Stand-Up meeting during daily PAR to monitor for appropriate and timely notification of resident, physician, and family member.
- Random chart reviews of residents that have experienced a change, that meet the regulations requirement for notification, will be conducted by ADNS to monitor for compliance, and reviewed in facility PAR meeting.

Monitoring of action/quality assurance program

- Results of audits performed by Unit Managers and DNS will be reported to the Facility Practices Review, Monthly x 3 months then quarterly there after, for review and forwarded to Quality Assurance Committee for further recommendations.
- Results of random chart reviews conducted during facility PAR meeting will be reported to Facility Practices Review Monthly x 3 months then quarterly there after, for review and forwarded to Quality Assurance Committee for further recommendations.
- Unit Managers and DNS responsible for on going monitoring.

Date of Compliance 9-16-08

Bureau of Facility Standards

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C 000	16.03.02 INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiency was cited during a complaint investigation of your facility. The surveyors conducting the survey were: Marcia Key, RN, BSN, WOCN Arnold Rosling, RN, QMRP Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	RECEIVED SEP 23 2008 FACILITY STANDARDS	
C 155	02.100,08 NOTIFICATION OF CHGE PTNT/RSDNT STATUS 08. Notification of Change in Patient/Resident Status. There shall be written policies and procedures relating to notification of next of kin, or sponsor, in the event of a significant change in a patient's/resident's status. This Rule is not met as evidenced by: Please refer to F 157 as it addresses the facility's failure to ensure the treating physicians and residents' families/responsible parties were immediately notified after accidents involving residents in the facility.	C 155	see attached P.O.C. For Ftag 157 Trinity Mission Health & Rehab. of Holly, L.P. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed. Solely because it is required by the provision of the Federal and State Law.	9-16-08

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